DOCUMENT RESUME

ED 130 168 CG 002 003

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TITLE Toward Further Explication of the Psychotherapeutic Process.
SPONS AGENCY National Inst. of Mental Health (DHEW), Rockville, Md.
PUB DATE 13 Nov 63
NOTE 22p.; Paper presented at the Multidisciplinary Group Psychotherapy Assembly (Lexington, Kentucky, November 13, 1963)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Behavior Change; *Communication Skills; Counseling Theories; *Helping Relationship; *Interaction Process Analysis; *Personality Change; Psychiatry; State of the Art Reviews; *Therapeutic Environment

ABSTRACT

The authors examine the dimensions of effective psychotherapy in an attempt to determine common variables of theoretic models which seem successful. Three such variables are discussed at length--concreteness, intensity and intimacy, and ambiguity. Assuming that one is not born with good therapist skills, one must learn them. Research and its implications for the progress of the therapeutic personality change process are discussed. (HJ)

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ED130168

Toward Further Explication of the Psychotherapeutic Process

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Invited Address
Multidisciplinary Group Psychotherapy Assembly
Department of Mental Health
Commonwealth of Kentucky
Eastern State Hospital
Lexington, Kentucky
November 13, 1963

Coordinator: Edgar A. Moles
Sponsor: H. L. McPheeters
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Toward Further Explication of the Psychotherapeutic Process

Many recent research and theoretical efforts reflect attempts to come to grips with the essential elements of therapy that lead to constructive behavioral changes in patients and which cut across the parochial "schools" of therapy. While the extractions reflect to a large degree the disciplines and dispositions of their formulators, there are constant threads running through many of the approaches. Common abstractions such as empathy, the ability of the therapist to sensitively and accurately understand the client, have taken on a traditional character as they have been advanced by psychoanalytic theorists, client-centered theorists and eclectic theorists.

To be sure, an element such as empathy has not stood alone. Other common variables, which have assumed a traditional character of their own, have served complementary roles in an equation accounting for therapeutic personality change. While these variables have given both impetus and directionality to investigations of the process of psychotherapy, current theoretical models are obviously incomplete.

As current research develops, it should be clearly anticipated that present models must be expanded to include a multitude of therapist, patient and environmental variables, alone and in their various interactions, if we are ever to account for the total process of psychotherapy (Carkhuff, 1963a). Our research model to account for therapeutic personality change is the theory of the general linear equation, with each psychotherapy variable in the equation tested for the significance of its effect upon the variation in the indices of change (Truax and Carkhuff, 1963a).

Our research efforts have led us to explore variables beyond those tied directly to past theoretic models. One such variable, concreteness or specificity of expression, has emerged as an important ingredient of successful psychotherapy. In many ways it has been an implicit but forgotten element in many theoretic discussions of psychotherapy.

Concreteness

Although this characteristic of psychotherapy has not been explored in research, some inferences of the importance of concreteness for psychotherapy may be drawn from the literature of analytic, client-centered and eclectic theorists. Freud's (1950) initial position stressed two points, both of which remain basic to psychoanalytic theory: (a) the recovery of repressed memories, and (b) the handling of repressed affects. Relief from repression is emphasized as essential to successful therapy, if not an essence of successful therapy. From Freud's discussion, it is clear that even when these memories and affects are fantasy productions they are concrete and specific and not abstract. Rogers (1951) refers, in his discussion of empathic understanding, to the specific experiencing of the patient rather than to abstract experiencings.

In particular, some eclectic theorists (Ellis, 1959; Sullivan, 1954) have stressed the importance of specificity and the nontherapeutic character of abstract interactions. Thorne (1950) has been perhaps most emphatic on these points. He advocates concrete tutorial personality counseling emphasizing systematic learning, relearning or "unlearning" techniques, based upon intensive differential diagnosis of specific etiologic factors productive of maladjustment. Indeed, it would seem that psychotherapists in general regard a patient's discussion of abstractions as defensive rather than exploratory.

The critical nature of concreteness as an element which is present in successful psychotherapy emerged from a recent study (Truax, 1961; Truax and Carkhuff, in press, 1963) designed to look at a number of elements common to a wide variety of psychotherapies. Comparative evaluations were made of the roles of therapists empathy, genuineness, unconditional positive regard, leadership, responsivity, assumed similarity with patients and concreteness of expression along with several other variables.

Concreteness, a condition relatively under the direct control of the therapist, was defined as follows:

> A low level of concreteness or specificity is when there is a discussion of anonymous generalities; when the discussion is on an abstract intellectual level. This includes discussions of "real" feelings that are expressed on an abstract level. A high level of concreteness or specificity is when specific feelings and experiences are expressed-- "I hated my mother!" or ". . . then he would blow up and start throwing things"; when expressions deal with specific situations, events, or feelings, regardless of emotional content.

In the statistical analyses of 16 different therapist-influenced variables, in a study of open-ended group therapy led by experienced therapists of widely differing approaches, representing psychoanalytic, client centered and eclectic inclinations, concreteness was the most highly related to the criteria measures of the therapeutic process.

In addition, all of the therapist-influenced variables which related positively to the criteria were also found to be positively and significantly related to the concreteness variable. (Interestingly enough--and as might have been expected--concreteness correlated negatively with the sociability of the relationship, i.e. when the parties responded on a social basis.) Thus, cases with therapists who presented high conditions and cases where patients were deeply engaged in the process of therapy were most heavily loaded with specificity or concreteness of interaction. The concreteness of the therapeutic interaction appears clinically quite crucial.

Concreteness or specificity of the therapist's response would seem to serve at least three important functions. First, the therapist's concreteness ensures that the therapist's response does not become abstract and intellectual and thus, more emotionally removed from the patient's feelings and experiences.

Secondly, specificity encourages the therapist to be more precisely accurate in his understandings of the client and, therefore, even minor misunderstandings become quite clear when the feelings and experiences are stated in specific terms and corrections can be immediately made. Thirdly, and perhaps most important, the client is directly influenced to attend with specificity to problem areas and emotional conflicts. In short, concreteness seems to function so as to (1) ensure emotional proximity that is, that the therapist be close to the feelings of the patient; (2) enhance the accuracy of the therapist's response so that corrections can be made; and (3) encourage specificity in the client's efforts.

Concreteness or specificity, since it would appear to be less tied to one's "life style" might be more easily under the control of the therapist. Thus, while it might be difficult for the therapist to maintain control over the degree of his accurate empathy for a patient, his unconditional warmth for his patient, his own integration or even the intensity and intimacy of the interpersonal relationship, the degree of concreteness of communications appears more easily influenced or varied by him. In addition, concreteness appears to transcend the theoretical and emotional commitments to "schools' of therapy. Thus, as future research findings add to our store of knowledge concerning the role of concreteness, these learnings could be applied easily by psychoanalytic therapists, behavior therapists, client-centered therapists or eclectic therapists without the usual barriers presented by commitments to theories and "schools."

What this means for us as clinicians and helpers is that we be concrete in our interactions with patients if we want these interactions to be therapeutic. Thus we must concern ourselves with specific and real feelings, conflicts and problems. We must avoid abstract generalities. We must help the patient to tie his concerns in therapy or counseling to specific aspects of his life.

If, for example, the focal point of our interaction is facilitating some kind of vocational decision or adjustment on the part of the patient, we must avoid lengthy general discussions about such general abstractions as "stimulation" or "liesure" which the patient may offer as what he is seeking in a job. We might instead focus on the patient's very real feelings that people look down at "bakers" and he can't tolerate being look down upon in this way.

If we are concerned with the patient's relationship with his wife, then we must not alng dwell on such glittering generalities as "All wives and husbands have troubles sometimes." We might work for a level such as the patient's feeling that he just gets "all weak and helpless inside" when his wife starts "giving him hell for not being as good as other men."

Thus, concreteness has emerged in one of the very few studies in group psychotherapy of its kind (that is, a study exploring such a variety of dimensions) as the most significant of elements. Clearly, then, the aim in group psychotherapy is to maintain the discussions at a very concrete and specific, rather than abstract level.

Whether or not concreteness will prove to be a universally effective therapeutic ingredient or whether it will be qualified in its efficacy remains to be seen. Pope and Siegman (1962) suggest the possibility that therapist specificity is anxiety reducing when the content area is neutral but anxiety arousing when it is a very emotionally laden area. Further differential analyses are necessary.

Again, the intention here is not to emphasize the element of concreteness to the exclusion of others. Rather, it appears that concreteness operates most effectively in the context of high levels of the other posited therapeuti elements, such as empathy, as the correlations with other effective therapist variables attest.

What are some of the other facilitative conditions serving complementary roles in an equation accounting for therapeutic personality change? Some of

these conditions or dimensions have not yet attained the status prerequisite for research. They remain, nevertheless, critical clinical dimensions worthy of extensive exploration. One such dimension, that of intensity and intimacy, emerges as a potentially crucial therapeutic variable.

In attempting to abstract the common effective ingredients of effective psychotherapy, the sense of vital intensity and personal intimacy which characterizes this interpersonal interaction termed therapy seems somehow lost in the abstraction process. That is, the vital intensity and intimacy of the interpersonal contact which is so vividly experienced by patients in successful psychotherapy has been in large part untouched by current theory and research (Truax, Carkhuff, Bergman, et. al., in press, 1963).

Intensity and Intimacy

It is hypothesized that intensity and intimacy of interpersonal contact supplies the motivation which allows the patient to make use of the conditions offered by the therapist in the patient's own coming to explore and experience his inner self (Truax, 1962).

Stated more strongly, it is hypothesized that intensity and intimacy of interpersonal contact is a necessary antecedent to the exploration and experiencing of self in the context of psychotherapy.

Thus, the intensity and intimacy of interpersonal contact is seen as a "motor" which moves the process of psychotherapy. In this aspect the present conception of intensity and intimacy is a rather radical departure from existing theories of psychotherapy where the presence of incongruence or anxiety is seen as the motivating force which moves the patient into the process of psychotherapy. In respect to this latter point, the present authors would agree that anxiety or incongruence in the patient is closely tied to movement and exploration or experiencing in psychotherapy. However, it is here seen not as the motivating force, but rather as the signal to both the patient and the therapist for identifying material of emotional

significance that would be therapeutically desirable to explore and experience.

The above is not meant to imply that anxiety or incongruence is not a motivating element in bringing the patient to ask for therapy, nor to imply that anxiety or incongruence is not a motivating element in catharsis. The above hypothesis (which is only offered in the spirit of promoting thought) refers only to exploration and experiencing of the self by the patient.

Thus, it would be predicted that relative amounts of anxiety or incongruence would determine what is explored and experienced in psychotherapy, while the degree of intensity and intimacy of interpersonal contact in psychotherapy would determine the extent to which exploration and experiencing by the patient occur in psychotherapy.

In the absence of intensity and intimacy otherwise effective psychotherapy involves the patient, at best, in exploration of self without experiencing of the inner feeling process. Thus, intellectual insight may be possible but the experiencing necessary for the "working through" operation is not present. Without intensity and intimacy psychotherapy often becomes a mere intellectual game.

While the dimension of intensity and intimacy of interpersonal contact has not yet been researched in the context of group psychotherapy there is some growing evidence of its efficacy in individual therapy. In an analysis of over one thousand ratings on 13 patients, the correlations with the outcome criteria were found to be in the predicted direction, and at an acceptable level of significance in the case of a final outcome criteria, including psychological test change estimates and percent of time spent in hospital (Truax, 1962a). In addition, the level of intensity and intimacy offered by the therapist in any given moment of therapy correlated at statistically acceptable levels of significance with patient depth of intrapersonal exploration (Truax, 1962b).

Further, it has been demonstrated that the therapists involved in the

research were able to offer the same level of intensity and intimacy to old as to young patients, to low socio-educational status patients as to high status patients, etc. (Truax, 1962c). The direct implication is that intensity and intimacy are characteristic of the therapist rather than the patient. This has major implications for the practice of psychotherapy since it indicates that therapists who are, by research definition, very high socio-educational status persons, can and do offer equally high intensity and intimacy to either high or low socio-educational status clients.

Intensity and intimacy of interpersonal contact by the therapist, then, involves an intensity in voice and manner which has a compellingly personal note. There is accentuated feeling tone and a voice and manner which is both deeply concerned and confidential. The therapist is preoccupied with the patient and his experiences or feelings and a heightened atmosphere is achieved by the therapist's "hovering attentiveness." There is a combination of alertness and absorption in the patient by the therapist which communicates a vital concern. The voice combines both depth of feeling and solicitous closeness which communicates an accentuated feeling tone and a fervid concentration. A profound seriousness and sincerity are central ingredients. The entrancing quality is clear in voice or manner of the therapist.

At the lower end of the intensity and intimacy continuum the therapist is subdued and distant in voice and manner. There is an aloofness from feelings and a formal, conventional, or reserved atmosphere. There is a remoteness or detachment which makes the therapist clearly an outsider or stranger. There is an inattentiveness or indifference which defines the therapist as unconcerned. Thus, the total interaction may take on a cool or intellectual flavor, at best.

Thus, there is hypothesized a unitary dimension of intensity and intimacy ranging from aloof remoteness to intense absorption.

For us as clinicians this means that when we communicate a bored inattentiveness and indifference to the patient's communications or his present "being", we <u>are not</u> therapeutic. When we are disinterestedly attentive and not personally concerned with what the patient is saying or being, we <u>are not</u> effective therapeutic agents.

It is only when we communicate a concerned attentiveness, connoting an accentuated feeling tone and a closeness, that we are therapeutically facilitative. When we are vitally concerned and preoccupied with the patient's experiences and being, when there is a note of deep concern and intimacy, then can we provide the necessary conditions for the patient's therapeutic growth.

In terms of group therapy, this attentive and intimate concern goes beyond the individual patient. The therapist must attend with intensity to the various interactions, whether overt interactions or implicit interactions. In many ways, then, the job in group therapy is a more difficult one than in individual therapy, that is, to attend with intensity to the feelings and reactions of those patients in the group who may not be talking at a given moment in time.

By focusing all of his attention upon the client and all of his effort upon receiving communication (both verbal and nonverbal), the therapist will tend, automatically, to provide relatively high levels of the following conditions: (1) non-conditional positive regard; (2) accurate empathic understanding; and (3) self-congruence or genuineness within the relationship.

By focusing upon what the patient is "being", what the patient is communicating, the therapist does not have time or effort left over to reflect upon how what the patient says relates to his own ideals, norms, or code of conduct, so that, automatically, an evaluative conditional regard is not communicated. The intensity and intimacy of interpersonal contact by the therapist itself communicates a non-conditional positive regard -- a

message of "what you are, what you feel, and what you experience are important to me." In short, it communicates clearly "You are important to me."

Intense focusing upon the patient's "being" facilitates accurate empathic understanding by allowing the therapist to make full use of subtle, nonverbal communications--such as small facial or postural changes which might be missed by a less attentive therapist. By intent concentration on the patient the therapist will insure that errors in accurate empathy are recognized. Also, the therapist will be able to immediately sense when the language he uses to communicate is received by the client with different meanings. He will be able to sense when his response does not exactly fit, and then in mid-sentence he can shift his own response to correct for language or content errors. In short, it makes possible the moment-to-moment contact necessary for accurate empathic understanding and clear communication.

Finally, a high level of intensity and intimacy tends to minimize incongruence in the therapist. If the therapist is intently focused upon the client, then the therapist does not have the time or energy available which would make it possible for him to relate what the client says or feels to himself. Thus, he does not tend to draw from the client's communication some self-referent or personal implications. If personal implications are not drawn, then the therapist is less likely to become threatened in the relationship. Since defensiveness or self-incongruence are reactions to perceived threat, then, if personal implications are not drawn, self-congruence or genuineness is more likely to be maintained within the relationship. By focusing intensely upon the client, the possibility that the therapist will become bound up in the anxiety and emotions of the client is minimized, since this possibility would require that the therapist pull back into his own feeling process and to that extent be inattentive of the patient's "being".

Thus far we have dealt primarily with therapist-offered conditions which cut across the differing therapeutic orientations and which seem effective

therapeutic ingredients for all patient populations. Perhaps how heavily these elements are weighted will be to some degree contingent upon the patient population being treated. That is, some patient populations may be treated more therapeutically when some therapeutic elements are emphasized and others de-emphasized.

The dimension of ambiguity in therapy is one which serves to emphasize different therapist-offered conditions according to the population being treated. While the dimension of ambiguity may not appear to be one of the necessary or sufficient conditions of therapeutic personality change, such as the hypothesized therapist conditions of self-congruence, accurate empathy and unconditional positive regard, it may, however, operate to facilitate or impede the efficacy of the other critical conditions.

Ambiguity

While ambiguity has a long tradition in psychotherapeutic literature (Eckstein, 1952), it is felt by many that it is a dimension which has been insufficiently exploited (Luborsky and Strupp, 1962). Ambiguity, an attribute of stimulus situations which elicits different responses, might be broadly conceptualized as the extent to which various factors or characteristics of the therapy situation as a whole tend to maximize or minimize the range of the therapist's and patient's behavior (Haggard, 1962).

In terms of therapist variables alone; ambiguity might be operationally defined in terms of how the therapist commits or defines himself in therapy, certainly a potentially critical aspect in forming a "personal relationship (Carkhuff, 1963)." A therapist may define himself, then, by such things as: (1) the closeness, variability and other characteristics of the relationship expected by the therapist; (2) the topics or content which he considers appropriate for consideration; (3) the therapist's values in terms of the therapeutic goals he sets up, whether they are preconveived or evolve out of the process; (4) the procedures and techniques which he employs; (5) the

level of activity of the therapist; and (6) the anxiety level, in both therapist and patient, with which the therapist operates. While these are by no means exhaustive, they are possibly major and crucial aspects of the ways in which the therapist is able to influence the therapeutic process by the degree to which he defines himself. Implicit, of course, and critical, is the client's perception of the characteristics offered by the therapist.

Many theories have indicated that when utilized in working with the emotionally disturbed, especially neurotic type outpatient populations, the functions of ambiguity include: (1) the investment by clients of those responses which are most heavily loaded with the unique aspects of their life history; (2) eliciting information about the general nature of a client's defense; and (3) eliciting the client's irrational feelings (Bordin, 1955, 1955a). The literature has indicated the need for the clients' having anxiety or concern about their problems in order for therapeutic progress to be possible. It is felt by many that ambiguity facilitates this anxiety and thus facilitates the therapeutic process with the emotionally disturbed (Frank, 1959; Krasner, 1962). Ambiguity not only frees the individual to behave in a greater variety of ways but may also permit such phenomena as transference to emerge and flourish. Thus, it would seem that ambiguity might be useful in many clinical situations, especially with neurotic outpatient populations. However, there are suggestions to indicate that modifications of any generalizations which we might make to other populations are in order.

It may not be desirable for the therapist to remain ambiguous with possibly two client populations, schizophrenics and normals, specifically situationally disturbed normals. The schizophrenic or schizoid personality is often desperately in need of, among other consideration, confirmation of their reality assessments. In addition, Dibner's (1958) finding that

anxiety is positively related to ambiguity in an interpersonal relationship suggests that the anxiety produced in an ambiguous situation may be overwhelming for the schizophrenic client. It would seem that schizophrenic clients would often have to know the boundaries and extensions of the prospective relationship. The therapist must, then, define himself in a personal way, for the inner disturbances of the schizophrenic client often make it difficult for him to perceive the conditions which the therapist offers.

There is a growing awareness among therapist of just such a dimension of ambiguity-nonambiguity. Gendlin, in a personal communication, stresses the schizophrenic's need for a sense of "connectedness," a personal and meaningful kind of direct and warm connection with a "real" person. He (1962) suggests that effective psychotherapy with schizophrenics appears to be a largely personal, expressive and concretely experiential or subverbal process. Seeman (1962) emphasizes that one of the major tasks of the therapist is to restore the integrity of communication, which has been shattered in the client by experiences of danger from others: "The therapist can do this best by communicating with immediacy and integrity himself (p. 212)." Truax (1961) focuses on (1) the responsivity of the therapist which acts so as to insure that any errors in accurate empathy by the therapist are corrected immediately, and (2) the concreteness or specificity of the therapist's response which acts to insure emotional proximity and enhance the accuracy of the therapist's responses. Rogers (1962) acknowledges that a quality of "conditionality" may facilitate therapy with psychotics: "...these psychotic individuals (may) perceive a conditional attitude as meaning that the therapist cares where an unconditional attitude may be interpreted as apathetic noncaring (p. 423)." Thus, there is increasing recognition for the low tolerance of schizophrenics for ambiguous situations. It seems that the schizophrenic can't tolerate ambiguity! The "normal" often won't!

Briefly, the normal's concerns are more likely to be of the situational and specific variety and he is not likely to be amenable to a relationship in which the therapist remains overly ambiguous (Carkhuff and Drasgow, 1963). Often he doesn't "want" his anxiety level raised. He feels that he has been functioning "well" in most respects and doesn't want to "play games." But he does have concerns which distress him! For example, he may be concerned about things vocational, such as changing jobs, fields or moving up within his a bility range. To follow through with the example, he may have questions about the nature of the aspiration field and level and the pre-requisites for entrance. There may even be some questions about the existence of other potential aspiration fields and levels. He may be in conflict about different possibilities. In any case, he often seeks help in exploring the current realities. Very often he is in need of the briefest of help--sometimes only information is necessary--in order to help make specific decisions. On occasions, longer term help may be necessary to help him resolve certain conflicts. In either event, there is a growing belief by many that a more-structured and direct, straightforward, unambiguous approach will likely be most efficacious (Bordin, 1955; 1955a).

While the dynamics vary with the differential diagnoses, it appears that ambiguity might well be an influential dimension of the therapeutic process. Variations in the degree of ambiguity may operate to facilitate or retard the effect of the posited necessary conditions of therapy. Luborsky and Strupp (1962) sum it up: "There (is) general recognition that just as there is no one formula for effective therapist behavior, so there are some patients who need ambiguity and nonexpressive therapist, while others need the opposite qualities of the dimension (p. 317)."

What this means for us as clinicians is that characteristics of the patient populations with whom we are dealing can determine to some extent how therapeutically effective we are in our therapy contacts. The patient

population characteristics determine, in effect, how heavily we might weight therapist-offered conditions such as the therapist's congruence which is, in turn, to be sure, related to the dimension of ambiguity in therapy. We have concerned ourselves today with one dimension, ambiguity, which interacts with patient population characteristics. An awareness of a dimension which we here have called ambiguity will facilitate the therapist's operation with differentially diagnosed group psychotherapy populations. Such an awareness will enable us as therapists to bring ourselves to bear most effectively in therapy according to the characteristic of the patient population.

In dealing with schizophrenics, for example, it would seem to be increasingly important for the therapist to define himself as a "clear" and "real" person and to decrease the patient's usual anxiety reaction to ambiguous stimuli. The therapist can make himself known with immediacy and integrity. The therapist can attempt to make known to the schizophrenic patient the boundaries and extents of the therapy which he is offering. A "real" therapist can offer the prospect for the "connection" with the outside would which the patient cannot alone make for himself.

An Overview

To sum, then, what are the messages of the foregoing presentation? They are as follows: (1) to be concrete and specific in dealing with the patient's feelings, problems, situations and events described is to be therapeutically effective, especially in the context of high levels of other conditions; (2) to be intense and intimate, that is, vitally concerned and fervently attentive to the patient's communications and "being" is to be efficacious therapeutically; (3) to have a more clear awareness of the relative roles of therapeutic conditions according to the patient population being treated (and we have here in mind the ambiguity dimension which have considered at length, especially in its relationship to hospitalized schizophrenics

populations) is to increase the probability of efficacy in therapy.

The more that we dig into the dimensions of effective psychotherapy, the more we realize how complex a process this is. The area of psychotherapeutic treatment is as complex as the mental and emotional processes with which it deals, if not more so.

The conditions for this learning, re-learning or un-learning process are at least as complex as the conditions which led, in its long evolution, to psychopathology in the first place. Indeed, the conditions for psychotherapeutic growth may be the reverse or the antithesis of the long-term conditions of the pathological development. One suggestion is, then, that the absence of concerns with specific feelings, problems and emotional conflicts contributed significantly to the patient's pathological development (the concreteness dimension). The suggestion is that the absence of any real vital concern and attentiveness had something important to do with the patient's present pathological development (the dimension of intensity and intimacy). The suggestion is that the significant people in the schizophrenic's development were not "real" and were not clear (the ambiguity dimension).

The complexness of these therapeutic conditions clearly suggest, for example, that a simple insight or two is not going to produce major change in the patient's attitudes and behavior which are a long time evolvement, <u>particularly</u> if the insight comes from another person and <u>particularly</u> if this other person is not operating in the context of high levels of some of the conditions which we have considered today.

How do we put all of these conditions together in one therapeutic contact? To be sure, these conditions are really abstractions of what effective and, often, experienced therapists have come to know as effective means for producing therapeutic change. Often they are offered in the therapist's words, attitudes, postures and gestures which have come to be

quite natural to the therapist's makeup. Clearly, the conditions needn't be artificial because they are complex.

On the other hand, while we all know what we call "natural" therapists, these therapists were not born with all of their effective ways of working with people, of involving these people in the therapeutic process. These therapists have, themselves learned how to deal effectively, and more effectively, with others in a helping relationship.

Clearly, while we weren't born with the precise ways for dealing effectively with patients, most of us here today were born with the potential for learning how to become effective therapeutic agents of varying degrees (Truax and Carkhuff, 1963a; Truax, Carkhuff and Douds, 1963).

In addition, then, to being real and not phony, to being warm and understanding, the prospective helper can learn to attend with intensity and intimacy to concrete and specific instances of related feelings and problems and can learn to make himself and the boundaries and extents of the therapeutic process (in which he is attempting to engage the patient) known to the patient in degrees varying with the patient population with which he is working.

The dimensions covered today are by no means exhaustive in our attempt to account for the process of therapeutic personality change. They are, however, critical dimensions deserving of further attention in clinical practice and research.

It is clear that we do not have the final answers. Our theories do, however, serve as stimuli to furthering our creative thinking and doing in this most significant of all areas, the area of mental health. In this regard, we are mindful of Hebb's (1959) succinct statement of the mandate incumbent upon the investigator:

> ...theory is not an affirmation but a method of analysis and can't produce any belief. Knowledge progresses by

> stages, so the theory one holds today must be provisional, as much a formulation of one's ignorance as anything else, to be used as long as it is useful and then discarded. Its function is to organize the available evidence and guide the search for better evidence. It is really only a working assumption which the user may actively disbelieve (p. 270).

It would appear that many of the potentially relevant and meaningful elements of therapeutic change remain as yet unknown in all of their aspects. The quest for an equation to account for therapeutic personality change will be, in all probability, an unending process of researching some old dimensions and exploring some new dimensions - as we have done today.

In the very real meantime, of our urgent needs in the area of mental health, we have a responsibility to put to their most effective use those known elements or conditions pointed to by our best available evidence as the most significant therapeutic variables. Finally, in putting our best known effective ingredients to use we must neither close ourselves off to their modification and qualification nor disallow the emergence of new dimensions in this most significant of all processes - the process of therapeutic personality change.

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